		FOR OHF USE															IMPORTAN	T NOTICE			$\overline{}$
								LL1								THIS	AGENCY IS	REQUESTING DISCLO	SURE C	OF INFORMATION	
																THAT	IS NECESSA	ARY TO ACCOMPLISE	THE ST	ΓATUTORY	
												2	001			PURP	OSE AS OUT	LINED IN 210 ILCS 45	/3-208.]	DISCLOSURE	
												STATE O	FILLING	IS		OF TH	IIS INFORM/	ATION IS MANDATOR	Y. FAII	LURE TO PROVIDE	
											DEPA	ARTMENT						ON ON OR BEFORE TI			
										J	INANCIAL	AND STA	HISTICAL	REPO	RTFOR			TION OF PROGRAM			
												-TERM C						VED BY THE FORMS			
												(FISCAL				IIASI	DELIVATI RO	VED BT THE TORMS	WIZINZ	OLIMEIVI CEIVIER.	+
												(130112	1 201	1							+
																					+
I.	IDPH I	Facility ID Numbe	r:			001152	28						II.	CERTI	FICATIO	N BY AUTHO	RIZED F	ACILITY OFFI	CER		
														_							-
	Facility	Name: MEA	DC)W MA	NOD																
	racinty	Name: NEA	DC) W IVIA	NUK																-
		000 17	Щ											I hav	e examin	ed the contents	s of the ac	ccompanying rep	ort to	th€	
	Addres	s: 800 Mc AD	AM	DRIV	Ľ			TAYLORVILLE			62568										
			Nu	mber				City			Zip Cod	le		and cer	tify to the	best of my know	owledge a	nd belief that the	said	contents	
														are true	. accurate	and complete	statemer	nts in accordance	e with		
	County	: CHRISTIA	N											annlica	hle instru	ctions Declar	ation of n	reparer (other the	an nro	vider)	+
	County	. 0111131111																arer has any kno			+
	Tolonha	one Number:	-	(217) 82	4 227	+	For #	(217) 287-7763						is base	u on an m	iormation of w	nich prep	arer nas any kno	wieug	je.	
	reiepiio	one Number:		217) 02	24-227	/	гах#	(217) 287-7703									LL				
	100.	N.V.												Inter	itional mis	srepresentatio	n or falsifi	cation of any inf	ormat	ion	
	IDPA I	D Number:		370840	530001									in this c	ost repor	t may be punis	hable by	fine and/or impri	sonm	ent.	
																					+
	Data of	Initial License for	· Cu	rront (Junor	c•		1963							(Signed)						
	Date of	Tilitiai License ioi	Cu	irrent (JWHEIS	5.		1903					O.C.		(Signeu)					(D-4-)	<u> </u>
													Officer							(Date))
	Type of	f Ownership:											Admini	strator	(Type or	Print Name)	JERRY	W. JENNINGS			
													of Prov	ider							
		VOLUNTARY,N	ON	DDOL	TT		*7	DD ODDIET A DX		-	COVEDNME	NITAT	011101	luci	(Trials)	CONTROLL	7 D				+
					11		Λ	PROPRIETARY		,	GOVERNME	NIAL			(Title)	CONTROLLI	LK				
		Charitable	Cor	p.				Individual			State										
	-			¥.							~ .				(01						+
		Trust						Partnership			County				(Signed)						
-	IRS Ex	emption Code						Corporation			Other									(Date))
	LIKO LIA	puon couc									Other		D. 1.1		(D.: . 4 N					(Date)	<u>'</u>
								X "Sub-S" Cor	•				Paid		(Print Na	-					
								Limited Liab	ilitv	Co.			Prepar	er	and Title)					
								Trust								,					+
			\vdash												(E' . N						+
								Other							(Firm Na	ıme					
															& Addre	ss)					
													-			,					+-
															(Telepho	ne) (')		Fax #		1
															, .T	MAIL TO: O	FFICE O	F HEALTH FINA			+
	In the	event there are fur	the	r anesti	ons oh	out this	renor	t nlease contact:										ENT OF PUBLIC			+-
		JERRY W. JENN			ons an				(21'	7) 787-85	20		_			201 S. Grand			AID		+
	14ame:	JEKKI W.JENN	ш	N)			reiepi	none Number:	(41	1) 101-03	טע		-						Dha-	0 # (217) 702 14	630
			\vdash											1		Springfield, II	J 02/03-U	UU1	rnon	e # (217) 782-10	J3U
			\vdash											1							+

								STATE OF ILLIN	OIS										Paş	ge 2
Facil	ity Nan	ne & ID Numb	er	MEADOW	MANOR					#	0011528	R	eport	Period E	Beginning:		05/01/00)	Ending:	04/30/01
	III.	STATISTICA	L DAT	A						D.	How many	bed-hol	d days	during	this year we	ere pa	id by Pub	lic Aid	?	
		A. Licensure/c	ertifica	tion level(s)	of care; en	ter number	of beds/bed days,					(1	Do not	include	bed-hold da	ys in	Section B	.)		
		(must agree	with lic	ense). Date o	of change ir	ı licensed b	eds													
										E.	List all serv	ices pro	vided	by your	facility for	non-p	atients.			
		1			2		3	4		(E.g., day car	re, "me	als on	wheels".	, outpatient	thera	py)			
										NO	ONE									
	Beds	s at						Licensed												
	Begin	ning of		Licens	sure		Beds at End of	Bed Days During		F.	Does the fac	ility ma	intain	a daily	midnight ce	nsus?		YES		
	Repor	t Period		Level o	f Care		Report Period	Report Period												
	_									G.	Do pages 3	& 4 inc	lude ex	xpenses 1	for services	or				
1				Skilled (SI	NF)				1		investments	not di	ectly r	elated to	o patient ca	re?				
2				Skilled Pe	diatric (SN	F/PED)			2		YES		N	Ю	X					
3		150		Intermedi	ate (ICF)		150	54,750	3											
4				Intermedi	ate/DD				4	H.	Does the BA	LANC	E SHE	EET (pag	ge 17) reflec	t any	non-care	assets	•	
5				Sheltered	Care (SC)				5		YES		N	O	X					
6				ICF/DD 1	6 or Less				6											
										I. (On what dat	e did y		_	ing long ter	m car	e at this l	ocatior	1?	
7		150		TOTALS			150	54,750	7	I	Date started		1	963						
										J.	Was the faci			d or leas	ed after Jan	uary		-		
		B. Census-For	the ent			_		_			YES	L	ate				NO	X		
		1		2		3	4	5												
	Level	of Care			s by Level	of Care and	d Primary Source of	f Payment		K.	Was the fac	ility ce								
				Public Aid	D •		0.1	m . 1			YES	. .	Γ	NO	X		ES, enter		er	
_	CNIE			Recipient	Priva	te Pay	Other	Total		- 1	of beds certi	tied			and	lays o	f care pro	vided		
	SNF	ED							8											
	SNF/P	ED		·	1	£ 110			9	Mo	edicare Inte	rmedia	ry							
	ICF/D	D.		21,074	1	6,418		27,492	10	117	ACCOUNT	PING P	ACTC							
	ICF/D	ט							11	11	. ACCOUN	HING E	SASIS		MODIE					
	SC DD 16	OR LESS							12	A .	CCDUAL	v			MODIFIE CASH*	<u>υ</u>		CASI	T.	
13	16 עע	OK LESS			1				13	A	CCRUAL	X			CASH*	-	1	CAS	1"	
14	TOTA	LS		21,074		6,418		27,492	14	Is	s your fiscal	vear id	entical	to your	tax year?		YES	X	NO	
				==,0::		-, -		,->2		-	, 5ur 115tur								-10	
		C. Percent Oc			5, line 14 di		tal licensed				Tax Year:		4/30/01		Fiscal Year		04/30/01			
	1	bed days or	ı line 7	column 4)		50.21%				* /	All facilities	other th	an gay	vernmen	tal must rei	nort o	n the acci	ual ha	sis.	

					STATE OF IL						Page 3	\top
	Facility Name & ID Number	MEADOW MA			#	0011528	Report Period	Beginning:	05/01/00	Ending:	04/30/01	
	V. COST CENTER EXPENSES (thro	oughout the report	, please round t	o the nearest d	ollar)							
			osts Per Genera			Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	_
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	110,670	13,962	3,481	128,113		128,113		128,113			1
2	Food Purchase		101,732		101,732		101,732	(2,053)	99,679			2
3	Housekeeping	37,368	13,220		50,588		50,588		50,588			3
4	Laundry	24,691	15,278		39,969		39,969		39,969			4
5	Heat and Other Utilities			84,642	84,642		84,642	(4,200)	80,442			5
6	Maintenance	38,111	19,801	32,324	90,236		90,236	1,101	91,337			6
7	Other (specify):* Utility Workers	13,724			13,724		13,724		13,724			7
8	TOTAL General Services	224,564	163,993	120,447	509,004		509,004	(5,152)	503,852			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	755,191	32,177	3,112	790,480	(5,107)	785,373	789	786,162			10
10a	Therapy	16,780	62		16,842		16,842		16,842			10
11	Activities	21,254	1,691		22,945		22,945		22,945			1:
12	Social Services	18,710		2,396	21,106		21,106		21,106			12
13	Nurse Aide Training	4,068	69	5,131	9,268		9,268		9,268			1.
14	Program Transportation	,		ŕ	ŕ		,		,			14
15	Other (specify):*											1:
16	TOTAL Health Care and Programs	816,003	33,999	22,639	872,641	(5,107)	867,534	789	868,323			1
	C. General Administration	Í	, i		Í		, i		,			
17	Administrative	49,631		8,132	57,763	861	58,624	33,072	91,696			1'
18	Directors Fees				·		·	·	·			18
19	Professional Services			155,020	155,020		155,020	(145,559)	9,461			19
20	Dues, Fees, Subscriptions & Promotion	ns		10,750	10,750		10,750	(4,855)	5,895			20
21	Clerical & General Office Expenses	17,280	6,310	6,454	30,044		30,044	16,100	46,144			2
22	Employee Benefits & Payroll Taxes	,	,	177,161	177,161		177,161	10,086	187,247			2
23	Inservice Training & Education			1,223	1,223		1,223	77	1,300			2.
24	Travel and Seminar			1,621	1,621	(889)	732	1,414	2,146			24
25	Other Admin. Staff Transportation			,	,	(27)	-	,	, -			25
26	Insurance-Prop.Liab.Malpractice			63,633	63,633		63,633	346	63,979			20
27	Other (specify):*			15,250	15,250		15,250	(15,250)				2
28	TOTAL General Administration	66,911	6,310	439,244	512,465	(28)	512,437	(104,569)	407,868			2
	TOTAL Operating Expense		· ·	7	,	(=0)	, ·	(3 - 3 - 2)	,			
29	(sum of lines 8, 16 & 28)	1,107,478	204,302	582,330	1,894,110	(5,135)	1,888,975	(108,932)	1,780,043			2
_	*Attach a schedule if more than one t NOTE: Include a separate schedule d	vpe of cost is inclu	ded on this line	or if the total	exceeds \$1000.							

					STATE OF IL	LINOIS					Page 4	
	Facility Name & ID Number	MEADOW MA	ANOR			#0011528	Report Period	Beginning:	05/01/00	Ending:	04/30/01	
	V. COST CENTER EXPENSES (co	ontinued)										
			Cost Per Gener			Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	4
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total		10	
20	D. Ownership	1	2	3	4	5	6	7	8	9	10	
	Depreciation			24,425	24,425		24,425	6,978	31,403			30
	Amortization of Pre-Op. & Org.			10.016	10.016		10.016	(1.022)	16.003			31
32	Interest			18,816	18,816		18,816	(1,833)	16,983			32
33	Real Estate Taxes			28,615	28,615		28,615	3,873	28,615			33
34		acility & Grounds							3,873			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			71,856	71,856		71,856	9,018	80,874			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
	Ancillary Service Centers					5,135	5,135		5,135			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			82,125	82,125	5,135	87,260		87,260			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,107,478	204,302	736,311	2,048,091		2,048,091	(99,914)	1,948,177			45
	*Attach a schedule if more than one	e type of cost is i	ncluded on this	line, or if the t	otal exceeds \$10	000.						_
												1

								STA	ге с	F IL	LINOIS					Page 5	
Facil	ity Name & ID Number MEADOW	MANOR				#	# 0011528				eriod Beginning:	05/01/00			Ending:	04/30/01	
	ADJUSTMENT DETAIL		nses indica	ted below are i	on-allo						of Schedule V, pages 3 or	r 4 via colui	mn 7.				
		In colum	n 2 below,	reference the li	ne on w	hich th	he particular	cost	was	includ	ded. (See instructions.)						
				1	2		3										
				Ļ	Refer-		HF USE				there are expenses exper					ear in the	
	NON-ALLOWABLE EXPENSE	S		Amount	ence		ONLY			gen	neral ledger, they should	be entered	below.	(See ins	tructions.)	_	
	Day Care		\$			\$		1							1	2	
	Other Care for Outpatients							2							Amount	Reference	
	Governmental Sponsored Special Pro	ograms						3			Non-Paid Workers-Attacl			\$			31
	Non-Patient Meals							4		32	Donated Goods-Attach So	chedule*					32
	Telephone, TV & Radio in Resident	Rooms						5			Amortization of Organiza	ition &					
	Rented Facility Space			(4,200)	5			6		33	Pre-Operating Expense						33
	Sale of Supplies to Non-Patients							7			Adjustments for Related	Organization	1				
	Laundry for Non-Patients							8			Costs (Schedule VII)					Various	34
	Non-Straightline Depreciation			5,245	30			9			Other- Attach Schedule			mn 8	447		35
	Interest and Other Investment Income			(1,833)	32			10		36	SUBTOTAL (B): (sum o			\$	(76,071)		36
	Discounts, Allowances, Rebates & R			(832)	21			11				of SUBTO					
12	Non-Working Officer's or Owner's Sa	alary						12		37	TOTAL ADJUSTMENT	S (A) and	d (B))	\$	(99,914)		37
	Sales Tax			(2,998)	27			13									
14	Non-Care Related Interest							14		*Th	ese costs are only allowal	ole if they a	re nec	essary t	o meet minin	num	
15	Non-Care Related Owner's Transaction	ons						15		lice	nsing standards. Attach	a schedule	detaili	ng the i	tems include	d	
16	Personal Expenses (Including Transp	ortation)						16		on t	these lines.						
17	Non-Care Related Fees			(60)	20			17									
18	Fines and Penalties			(7,215)	27			18		C. Ar	re the following expenses	included in	Section	ons A to	D of pages 3		
19	Entertainment							19		and	14? If so, they should be	reclassified	into S	Section 1	E. Please		
20	Contributions							20		refe	erence the line on which t	hey appear	befor	e reclas	sification.		
21	Owner or Key-Man Insurance							21			e instructions.)		1	2	3	4	
22	Special Legal Fees & Legal Retainers	S						22		Ì	ĺ		Yes	No	Amount	Reference	
23	Malpractice Insurance for Individuals	S						23		38	Medically Necessary Tran	nsport.		\$			38
	Bad Debt			(4,794)	27			24		39	,						39
25	Fund Raising, Advertising and Promo	otional		(4,013)	20			25			Gift and Coffee Shops						40
	Income Taxes and Illinois Personal										Barber and Beauty Shops						41
	Property Replacement Tax			(243)	27			26			Laboratory and Radiolog	y					42
27	Nurse Aide Training for Non-Employ	yees						27			Prescription Drugs						43
	Yellow Page Advertising			(847)	20			28			Exceptional Care Program						44
	Other-Attach Schedule VENDING			(2,053)	2			29			Other-Attach Schedule	OXYGEN	X		5,135	10	45
30	SUBTOTAL (A): (Sum of lines 1-2	9)	\$	(23,843)		\$		30			Other-Attach Schedule						46
										47	TOTAL (C): (sum of lin	es 38-46)		\$	5,135		47
	OHF USE ONLY	50															
48	49	50	51		52												

		E OF ILLINOIS		Page 5A	
ME	ADOW MANOR				
	ID#	0011528			L
	eriod Beginning:	05/01/00			L
End	ling:	04/30/01			L
				Sch. V Line	L
ľ	NON-ALLOWABLE EX	KPENSES	Amount	Reference	L
1			\$		
2					L
3					L
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						STATE OF I	LLINOIS						Summary A	
	Facility Name & ID Number MEA	DOW MANOR	3			#	0011528	Report Perio	d Beginning:		05/01/00	Ending:	04/30/01	
	SUMMARY OF PAGES 5, 5A, 6, 6A			I AND 6I								. 9		
													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	6 I	(to Sch V, col.	7)
1	Dietary													1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,200)											(4,200)	5
6	Maintenance	447											447	6
7	Other (specify):*													7
8	TOTAL General Services	(3,753)											(3,753)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative		636										636	17
18	Directors Fees													18
19	Professional Services		(145,667)										(145,667)	19
20	Fees, Subscriptions & Promotions	(4,920)											(4,920)	20
21	Clerical & General Office Expenses	(832)											(832)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar		(636)										(636)	24
25	Other Admin. Staff Transportation		Ì											25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*	(15,250)											(15,250)	27
28	TOTAL General Administration	(21,002)	(145,667)										(166,669)	28
	TOTAL Operating Expense		` ′ ′											
29	(sum of lines 8,16 & 28)	(24,755)	(145,667)										(170,422)	29

				STATE OF I	LLINOIS								Summary B	
	Facility Name & ID Number ME	ADOW MANO)R			#	0011528	Report Peri	od Beginning:		05/01/00	Ending:	04/30/01	
	SUMMARY OF PAGES 5, 5A, 6, 6A	, 6B, 6C, 6D, 6F	E, 6F, 6G, 6H	AND 6I										
													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6 I	(to Sch V, col	l . 7)
30	1	5,245											5,245	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,833)											(1,833)	
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	3,412											3,412	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(21,343)	(145,667)										(167,010)	45

						STATE OF ILL	ΙN	OIS							Page 6	
Facility Name	e & ID I	Number MEADO	OW MANOR				#	0011528	Report	Perio	d Beginning:	05/01/00	Eı	nding:	04/30/01	
VII. RELATI	ED PAR	PTIES														
			wners and r	plated organizat	ione	(parties) as defined in th	ρi	netructions	Δttach ar	n add	itional sch	adula if nacass:	ar\	,		
71. Lintoi k	101011	1	Wileis alla i	Jacoa Organiza		2		noti dotiono.	Attaon a	- uuu	itional son	3	u. ,	/		
		OWNERS				RELATED NURSING HOM	FC				OTHED DE	LATED BUSINES	1 2 2	FNTITH	FS	
Name			Ownership %	Name		RELATED NORSING HOW	LS	City		Name		City	ו פו		Type of Busin	066
	HED SO	CHEDULE - PAGE 25	Ownership 70		JX/ A T	ESCENT CENTER, INC		GODFREY			ome Mngrs	SPRINGFIELD	L		MANAGEME	
SEE ATTAC.	HED SC	CHEDULE - LAGE 23		HILLTOP NURS				CHARLESTON		13g 11	ome wingrs	STRINGFIELD			MANAGEME	11
						NVALESCENT CENTER		JACKSONVIL								
	+					SCENT CENTER, INC		PETERSBURG								
	+			SUNRISE MAN		<u> </u>	Н	VIRDEN	,							
	+			SUNNISE MAN	JK U	r vinden, inc	Н	VINDEN	-							
	+						Н		-							
D 4	1 .	1 1 1 1 1 1	1 1	1. 6.4	•41		Ļ	4								_
				it of transactions w	_	lated organizations? This incl	ude	s rent,								-
manage	ment te	es, purchase of supplies	s, and so forth.		X	YES NO										-
TC	٠.	1 14 64	441	1.4.1		41 611 4 1 11 1		*41								
•					s mu	st be fully itemized in accorda	nce	with								-
the instr		for determining costs			_							_		0.754		_
1	2	3 Cost Per Genera	l Ledger	4	5	Cost to Related Organization					6	7			ference:	1
C -1 J1 - X 7	T :	T4		A 4		N					Percent	Operating Cost			ments for	
Schedule V	Line	Item		Amount		Name of Related Organizatio	n				Orymanshin	of Related			Organization minus 4)	
1 V	19	MANAGEMENT FEI	7 0	154,557		NURSING HOME MANAGE	r D e	SINC			Ownership 81.83%	Organization	e	Costs (/	(154,557)	
1 V 2 V		SEE ATTACHED SC		134,337		NURSING HOME MANAGE					01.03 70	69,149	Þ		69,149	_
3 V	19	ACCOUNTING				NURSING HOME MANAGE			T ALLOC	ATIC	N	8,890	-		8,890	
4 V	24	TRAVEL		636		TO TRANSFER 31% OF HO				71110		0,070			(636)	
5 V	17	ADMINISTRATIVE T	FRAVEL	330		TO ADMINISTRATIVE PEI					† †	636	l		636	
6 V	 										†	300			350	
7 V					1								T			
8 V					1								T			
9 V													Ī			
10 V																1
11 V]
12 V																1
13 V]
14 Total			\$	155,193								\$ 78,675	\$	*	(76,518)	1
												_				
* Total	must ag	ree with the amount re	corded on line .	54 of Schedule VI.												Ш

				STATE OF	ILLINOIS					Page 7	
Faci	lity Name & ID Number	MEADOW MANOR		#	0011528	Report Period	d Beginning:	05/01/00	Ending:	04/30/01	
VII.	RELATED PARTIES (continu	ued)									
	C. Statement of Compensatio		wners, Relatives and	Members of 1	Board of Directors.						
	NOTE: ALL owners (e		an 5% ownership)) and their r	elatives who rece	eive any typ	e of compe	nsation from	this home		
	must be listed of	on this schedule.									
	1	2	3	4	5		6	7		8	
							urs Per Work				
					Compensation		oted to this	Compensatio		Schedule V.	
					Received	•	d % of Total	in Costs		Line &	<u> </u>
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	ــــــ
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	⊥
	SAM KLEIN	PRESIDENT		44.81					\$ 1,890	17 - 7	1
	H. RAYMOND KLEIN	OWNER		37.02					1,891	17 - 7	2
3											3
4											4
5					OND KLEIN WER						5
6			,		ED ORGANIZAT			SATION			6
7			,		KLEIN AND H. R						7
8					SIX RELATED N						8
9					K FOR SAM KLEI	IN AND 10 H	OURS PER	WEEK			9
10			FOR H. RAYMO	ND KLEIN.							10
11											11
12											12
13								TOTAL	\$ 3,781		13
	If the owner(s) of this facility of the home(s) as well as t	he amount paid. THIS All	MOUNT MUST AGE	REE TO THE	AMOUNTS CLAIME	ED ON THE T	HE OTHER N	IURSING HOM	edule detailing		
**	This must include all for FAILURE TO PROPERLY										+
	ALL OTHER NURSING H										
							<u> </u>				

					STATE OF II	LLIN	OIS						Page 8	
	Facility Name	e & ID Number MEADOW N	IANOR		# 0011528	Repo	rt Period Beginning	;:	05/01/00]	Ending:	04/30/01		
	VIII ALLOC	CATION OF INDIRECT COSTS												
	VIII. ALLOC	CATION OF INDIRECT COSTS					Name of Re	later	l Organization	NII	DSING HO	ME MAI	NAGERS, INC	_
	A Are the	ere any costs included in this repor	t which were derived f	rom allocations of cen	tral office		Street Add		Organization				CE - SUITE B	$+\!-$
		ent organization costs? (See instruc			trai office		City / State		Code		RINGFIEL			+
	01 pm1	organization costs (see instru	12.	3 11			Phone Num	ber			787-8530			_
	B. Show t	he allocation of costs below. If nec	essary, please attach w	orksheets.			Fax Numbe	er			787-9840			
	1	2	3	4	5		6		7		8		9	
	Schedule V		Unit of Allocation		Number of		Total Indirect	A	amount of Salary	y				
	Line		(i.e., Days, Direct Cost	÷,	Subunits Being		Cost Being		Cost Contained		Facility	A	llocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among		Allocated		in Column 6		Units	(col.8	/col.4)x col.6	
1		SEE ATTACHED SCHEDULES	•			\$		\$				\$,	1
2														2
3														3
4														4
5														5
6														7
7						-								8
9														9
10								+						10
11														11
12														12
13														13
14														14
15														15
16 17						_								16 17
18						-								18
19				+						-				19
20														20
21														21
22														22
23														23
24														24
25	TOTALS					\$		\$				\$		25

						STATE OI	F ILLINOIS					Page 9	
Facil	ity Name & ID Number	MEAI	DOW N	MANOR	#	0011528	Report Period	Beginning:	05/01/00	Ending:		04/30/01	
	IV INCEDECT EXPENCE AND	DEAL	ECT /	THE TEAM EMPENIES			•						
	IX. INTEREST EXPENSE ANI												
	A. Interest: (Complete detail	is must 2		vided for each loan - attach a se	_			7	0	9		10	
	1			3	4	5	6	1	8	9			
					Monthly				Maturity	Intoxect		Reporting Period	
	Name of Lender	Relate	.d**	Purpose of Loan	Payment	Date of	A	ınt of Note	Date Date	Interest Rate		Interest	
	Name of Lender	YES	NO	r urpose of Loan	Required	Note	Original	Balance	Date	(4 Digits)			
	A. Directly Facility Related	IES	NO		Kequireu	Note	Original	Daiance		(4 Digits)		Expense	
	Long-Term	-											
1	Long-Term		I		T	Ī	\$	s			•		1
2							J.	4			Ф		2
3													3
4													4
5													5
	Working Capital												
6	FIRSTAR BANK		X	WORKING CAPITAL	INTEREST	08/25/99	289,726			VARIES		4,308	6
	STOCKHOLDERS	X		WORKING CAPITAL	INTEREST	06/26/00	289,726	289,726	06/30/2010	6.0000		14,508	7
8					II (I I I I I I I I I I I I I I I I I I	00/20/00	203,120	205,120	00/00/2010	0,000		11,000	8
Ť													
9	TOTAL Facility Related					-	\$ 579,452	\$ 289,726			\$	18,816	9
	B. Non-Facility Related*					_						-)	
10	v												10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$		14
	•					_							
15	TOTALS (line 9+line14)						\$ 579,452	\$ 289,726			\$	18,816	15
*	Any interest expense reported in	n this se	ection s	hould be adjusted out on page 5	, line 14 and, cons	equently, pa	ge 4, col. 7.						
	(See instructions.)												
**	If there is ANY overlap in owne	rship b	etween	the facility and the lender, this	must be indicated	in column 2	2.						
	(See instructions.)			,									

			STATE OF	ILLIN						Page 10	
	W MANOR				# 0011528	Repo	rt Period Beginning:	05/01/00	Ending:	04/30/01	
IX. INTEREST EXPENSE AND RE B. Real Estate Taxes	AL ESTATE TAX	EXPENSE (continued	1)								
D. Real Estate Taxes											
					et, "RE_Tax". The r	eal e	estate tax statemer	nt and			
1. Real Estate Tax accrual used on 200	0 report.	bill must accompan	y the cost report						\$	37,235	1
2. Real Estate Taxes paid during the ye	ear: (Indicate the tax	year to which this payi	nent applies. If pay	ment o	covers more than one year	ır, det	ail below.)		\$	27,926	2
2 11 1 () 1(1: 2 :	1' 1)									(0.200)	_
3. Under or (over) accrual (line 2 minu	s line 1).								5	(9,309)	3
4. Real Estate Tax accrual used for 20	1 report (Detail at	nd evnlain vour calculat	ion of this accrual o	n the	lines helow)				9	37,924	4
4. Real Estate Tax decidal used for 200	71 Teport. (Betair ai	ia explain your carculat	ion or this accidance	ii tiic .	lines below.)				J	31,724	<u> </u>
5. Direct costs of an appeal of tax asse	ssments which has I	NOT been included in p	rofessional fees or	other 2	general operating costs of	ı Sch	edule V, sections A, B	or C.			
(Describe appeal cost below									s		5
(сессия арреан сессия									·		_
6. Subtract a refund of real estate taxes	. You must offset t	he full amount of any d	irect appeal costs								
classified as a real estate tax cost plu	s one-half of any re	emaining refund.									
TOTAL REFUND \$	For 19		Attach a copy of	of the	real estate tax app	eal	board's decision.)	\$		6
7. Real Estate Tax expense reported or	Schedule V, line 3	3. This should be a con	nbination of lines 3	thru 6					\$	28,615	7
Real Estate Tax History:											
Real Estate Tax History.											
Real Estate Tax Bill for Calendar Ye	r: 1996	27,292	8				FOR OHF USE	ONLY			
	1997	27,798	9								
	1998	27,993	10			13	FROM R. E. TAX ST	ATEMENT FOR	2000 \$		13
	1999 2000	27,926 28,443	11 12			14	PLUS APPEAL COS	T EDOM LINE 5	S		14
	2000	20,443	12			17	1 LOG AIT LAL GOO	T I KOW LINE 3	Φ		14
LINE 4 - ACCRUAL 16/12 X \$28,	143 = \$37,924					15	LESS REFUND FRO	OM LINE 6	\$		15
						16	AMOUNT TO USE F	OR RATE CALC	ULATION \$		16
NOTES:	1. Please indicat	te a negative number b	v use of brackets() De	educt any overaccrual o	f					
TO IED.	taxes from p	rior year.	J asc of brackets	<i>j.</i> D(June any Overace dar o	-					
	2. If facility is a	non-profit which pays	real estate taxes,	you m	ust attach a denial of a	n					
	application fo	or real estate tax exem	otion unless the bu	ilding	is rented from a for-pi	ofit e	entity.				
	This denial	must be no more t	nan tour years	old a	nt the time the cost	repo	ort is filed.				
				1							

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

		200	ULUITO		WIT CALL	CL ICLIA	LESIA		1 / 1	A GIAIL		11	
FAC	ILITY NA	ME	MEADOW	MAN	NOR					COUNTY	CH	RIST	IAN
FAC	ILITY ID	PH LICE	NSE NUMB	ER	0011528								
CON	TACT PE	ERSON F	REGARDING	THI	IS REPORT	JERRY W	. JENNING	3S					
TELI	EPHONE	(217)78	37-8530				FAX #:	(217	7) 78	7-9840			
	6	c D	1 10 4 4 70	-									

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not 1 entered in Column D. Do not include cost for any period other than calendar year 2000

		(A)			(B)			(C)		(D)
										Tax
										Applicable to
	Ta	x Index	Number	Prop	erty Descr	iption		Total Tax		Nursing Home
1.	17-13-23	-402-018	3	MEADOV	V MANOR	WEST, IN	C \$	904.72	\$	904.72
2.	17-13-23	-402-002	2	MEADOV	V MANOR	, INC	\$	27,538.00	\$	27,538.00
3.							\$		\$	
4.							\$		\$	
5.							\$		\$	
6.							\$		\$	
7.							\$		\$	
8.							\$		\$	
9.							\$		\$	
10.							\$		\$	
						TOTALS	\$	28,442.72	\$	28,442.72
B.	Real Est	ate Tax	Cost Allocation	1!						

B. Real Estate Tax Cost Allocation

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services | VES | X | NO | | NO |

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. <u>Tax Bills</u>

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

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							STATE O	F ILLINOIS	6					Page 11
Facili	tv Nam	e & ID Number MEADOW MA	ANOI	R			#	0011528	Report Po	riod Beginning:			05/01/00 Ending:	Ü
		G AND GENERAL INFORMA							1	i i i g				
A.	Squar	e Feet: 35,452		B. General Constru	uction Type	: Exterior	MASONR	Y	Frame	STEEL & WOO	D	Nu	mber of Stories	1
C.	Does t	he Operating Entity?	X	(a) Own the Facilit	y	(b) Rent from	a Related C	Organization	l•		(nt from Completely U	Unrelated
												Org	ganization.	
	(Facili	ties checking (a) or (b) must co	mplet	e Schedule XI. Thos	se checking	(c) may complete Schedu	ile XI or Sc	hedule XII-A	A. See insti	ructions.)				
-	D		• • • • • • • • • • • • • • • • • • • •					D 1 / 10					4 6 6	
D.	Does t	he Operating Entity?	X	(a) Own the Equip	ment	(b) Rent equip	ment from	a Related O	rganizatio	1.			nt equipment from C	
	Œ	4:	1.4	C.L. L. VI C. T					VII D C	•		Uni	elated Organization	•
	(Facili	ties checking (a) or (b) must co	mpiet	e Schedule XI-C. 11	nose cneckii	ng (c) may complete Scho	eaule XI-C	or Schedule	AII-B. See	instructions.)				
T.	T :-4 -1	L -4h h i d)	L 41. :			41			4 4 - 41-:-					
Е.		l other business entities owned las, but not limited to, apartmen												
		as, but not limited to, apartmen atity name, type of business, squ						iiving facilit	ies, nurse a	ide training facili	ties, etc	:.)		
	List en	itity name, type of business, squ	are i	ootage, and number	r of beas/uni	its available (where appli	icabie).							
F.		his cost report reflect any organ	izati	on or pre-operating	costs which	are being amortized?				YES	X	NO		
	If so, p	lease complete the following:												
1	Total A	mount Incurred:					2 Number	of Vears O	ver Which	it is Being Amort	ized·			
							2. 144111501	or rears o	ver vvinien	it is being minore	izcu.			
3.	Curren	t Period Amortization:					4. Dates In	curred:						
				re of Costs:										
				(Attach a complete	schedule de	etailing the total amount	of organiza	tion and pro	e-operating	costs.)				
XI. O	WNER	SHIP COSTS:												
				1		2		3		4				
	A. Lar	ıd.		Use		Square Feet	Year	Acquired		Cost				
			1	NURSING H	OME			1963	\$	3,000	1			
			2	NURSING H	OME			1984		40,077	2			
			3	TOTALS					\$	43,077	3			

Facility Name &	ID Number MEADOW MANOR	,		STATE OF IL	#	0011528	Report Perio	d Poginning:	05	5/01/00 Ending:	Page 12 04/30/01
	RSHIP COSTS (continued)				#	0011526	Keport Ferio	и вединия:	05	/01/00 Enumg:	04/30/01
		win mant (Cas ingt	mations \ Down	all mumbans to ma	22004	dellan					
B. Bullo	ing Depreciation-Including Fixed Eq	urpment. (See insti			arest			7			
1		Z Z	3	4		5 C (P)	6	/ C: 1/1:		8	, , , , , , , , , , , , , , , , , , ,
n 1 x	FOR OHF USE ONLY	Year	Year	C 4		Current Book	Life	Straight Line			Accumulated
Beds*		Acquired	Constructed	Cost		Depreciation	in Years	Depreciation		ustments	Depreciation
4 50		1963		\$ 226,688	\$		25	\$	\$	\$	226,68
5 51			1967	289,148			30				289,14
6 49			1970	227,964			25				227,96
7											
8											
Impr	ovement Type**										
9 IMPROVEN			1979	5,775			15				5,77
10 IMPROVEN			1980	1,810			VARIOUS				1,81
11 IMPROVEN			1980	5,207			VARIOUS				5,20
12 IMPROVEN			1981	635			10				63
13 IMPROVEN			1982	36,795			15				36,79
14 ROOF			1984	3,000			15				3,00
15 IMPROVEN	ENT		1984	15,420		857	15			(857)	15,42
16 IMPROVEN			1984	44,410		1,776	15			(1,776)	44,41
17 IMPROVEN			1986	13,401		697	15	452		(245)	13,40
18 IMPROVEN	ENT		1985	2,016		106	15	72		(34)	2,01
19 BOILER			1986	966		50	15	65		15	93
20 ROOF			1987	1,878		60	15	125		65	1,76
21 AIR CONDI	ΓΙΟΝΕR		1987	3,749		160	15	250		90	3,62
22 IMPROVEN	ENT		1987	6,721		213	15	448		235	6,12
23 IMPROVEN	ENT		1987	2,539		81	15	169		88	1,69
24 IMPROVEN	ENT		1988	3,588		114	15	239		125	2,39
25 SPRINKLE			1989	890		28	15	59		31	59
26 IMPROVEN	ENT		1989	16,132		512	15	1,076		564	12,36
27 IMPROVEN	ENT		1990	4,004		127	15	267		140	2,67
28 IMPROVEN			1989	12,205		387	15	814		427	9,36
29 IMPROVEN	ENT		1989	842		27	15	56		29	56
30 IMPROVEN	ENT		1990	22,907		727	VARIOUS	987		260	10,04
31 IMPROVEN	ENT		1990	24,924		791	VARIOUS	1,320		529	13,86
32 IMPROVEN	ENT		1993	2,576		82	15	172		90	1,46
33 IMPROVEN	ENT		1993	3,604		114	15	240		126	2,04
34 IMPROVEN	ENT		1994	1,475		47	15	98		51	73
35 IMPROVEN	ENT		1995	42,600		1,092	20	2,130		1,038	13,84
36 IMPROVE			1995	2,471		63	15	165		102	1,07
*Total hada	on this schedule must agree with page 2.			See Page 12		: 70 £	A - A - I				

					STATE OF ILI							Page 12A
	e & ID Number	MEADOW MANOR				#	0011528	Report Perio	d Beginning:	05/01/00	Ending:	04/30/01
	NERSHIP COST											
B, B	uilding Depreciati	ion-Including Fixed Equipment. (ınd all		arest						
	1		3		4		5	6	7	8		9
Į į			Year				Current Book	Life	Straight Line			cumulated
	provement Type**		Constructe		Cost		Depreciation	in Years	Depreciation	Adjustments		epreciation
	NDITIONER		1996	\$	6,844	\$	176	15	\$ 456	\$ 280		2,508
	E DETECTORS		1996		981		25	15	65	40		361
39 SINKS	& FAUCETS		1996		2,698		69	15	180	111		990
40 WINDO	WS		1996		3,859		99	15	257	158		1,414
41 FIRE D	OORS		1996		784		20	15	52	32		286
	NDITIONER		1997		7,569		194	15	505	311		1,767
	OOR FRAMES		1997		10,035		257	15	669	412		2,341
	CLER REPAIRS		1997		1,127	1	29	15	75	46		263
45 FIRE D			1998		808		20	15	54	34		135
	NDITIONER		1998		1,820		47	15	121	74		303
	LARM SYSTEM		1999		8,250		212	20	413	201		1,032
	LOW VALVE		2000		1,999		51	15	133	82		144
49 WATEI	RHEATER		2000		3,813		98	15	254	156		339
50 BACKE	LOW VALVE		2000		3,998		103	15	267	164		289
51 AIR CO	NDITIONER		1999		2,985		77	15	199	122		381
52 DOORS	5		2001		4,450		5	15	25	20		25
53												
54												
55												
56												
57												
58												
59												
60												
61												
62												
63												
64												
65												
66												
67												
68												
69												
70 ITOTAL	(lines 4 thru 69)			\$	1,088,360	\$	9,593		\$ 12,929	\$ 3,336	\$	969,976

									STATE OF II	LL	INOI	IS						Page 13		
Facil	ity Name & ID N	lumbei	r	MEADO	W	MANOR			# 0011528			Report Peri	od B	eginning:	05/01/00	Ending	:	04/30/01		
	WNERSHIP CO																			
			ation-E	xcluding '	Tra	nsportation. (See	instructions.)													
	Catego						1					ent Book		aight Line	4			Accumulated		
	Equip						Cost			I	Depr	eciation 2		preciation 3	Adjustments		_	Depreciation 6		
71	Purchased in	Prior Y	Years		\$		171,996			\$		14,538	\$	16,549	\$ 2,011	VARIOU	U S	\$ 98,207	71	
72	Current Year						2,058					294		192	(102)			192	72	
73	Fully Depreci						252,737									VARIOU	US	252,737	73	
74	ASSETS	NO LO	ONGER	R IN SERV	VIC	CE	(79,615)											(79,615)	74	
75	TOTALS				\$		347,176			\$		14,832	\$	16,741	\$ 1,909			\$ 271,521	75	
	D. Vehicle Depr	eciatio	n (See i	nstruction	ıs.)	*														
	1			Mode			Year		4		Cur	rent Book	Str	aight Line	7	Life in		Accumulated		
	Use					and Year 2	Acquired 3		Cost		Dep	reciation 5	Dej	preciation 6	Adjustments	Years	8	Depreciation 9		
76								\$			\$		\$		\$			\$	76	
77																			77	
78																			78	
79																			79	
80	TOTALS							\$			\$		\$		\$			\$	80	
	E. Summary of	Care-R	Related	Assets							1							2		
										_	eferer							Amount		
81	Total Historic	cal Cos	t			(line 3 , col. $4 + line$	e 70, col.4 + line 75, co	ol.1	+ line 80, col.4)	+ ((Page	es 12B thru 12I, i	if ap	plicable)		\$		1,478,613	81	
82	Current Book	Depre	eciation			(line 70, col.5 + lin	ne 75, col.2 + line 80,	col	.5) + (Pages 12B	thi	ru 12	I, if applicable)				\$		24,425	82	
83	Straight Line	Depre	ciation			(line 70, col.7 + lin	ne 75, col.3 + line 80,	col	.6) + (Pages 12B	thi	ru 12	I, if applicable)				\$		29,670	83	**
84	Adjustments					(line 70, col.8 + li	ne 75, col.4 + line 80,	col	.7) + (Pages 12B	thi	ru 12	I, if applicable)				\$		5,245	84	
85	Accumulated	Depre	ciation			(line 70, col.9 + li	ne 75, col.6 + line 80,	col	.9) + (Pages 12B	thi	ru 12	I, if applicable)				\$		1,241,497	85	
	F. Depreciable N	Non-Ca	re Asse	ets Includ	ed i	in General Ledger	. (See instructions.)							G. Constructio	n-in-Progress					
		1				2	Current Book		Accumulated											
	Description & Y	ear Ac	quired			Cost	Depreciation 3		Depreciation 4	4	<u> </u>			Description				Cost		1
86					\$		\$	_	\$		86		92			\$			92	1
87											87		93						93	
88											88		94						94	
89											89		95			\$			95]
90											90		_							
91	TOTALS				\$		\$		\$		91		*	Vehicles use	ed to transpor	t resider	nts	to & from		
														day training	must be reco	rded in)	KI-F	, not XI-D.		
											<u></u>									
													**	This must agre	e with Schedule	v line 30,	colı	ımn 8.		

								S	STA	TE OF ILLI	NOIS										Page 14
Facil	ity Name & II) Number	MEA	DOW MA	NOR			#	ŧ	0011528				Report P	eriod	Beginning:		05/01/00	E	nding:	04/30/01
VII I	RENTAL CO	STS																			
	A. Building a		inment (Se	e instructio	one)																
	1. Name of	Party Holding	Lease:		J113. j	N/A															
				e taxes in	additio		l amount shown belo	w on lin	ie 7.	column 4?											-
		instructions							,	YES		NO									
	,																				
		1		2		3	4			5			6								
		Year		Number		Date of	Rental			Total Yea	ırs	Tot	tal Y	ears							
		Construct	ted	of Beds		Lease	Amount			of Lease	e	Renew	val (Option*							
	Original															10. E	ffective d	ates of curre	nt rental	l agreem	ent:
3	Building:						\$								3	Be	ginning	-			
4	Additions														4	En	ding				
5															5						
6															6	11. R	ent to be	paid in futur	e vears i	under th	e current
-	TOTAL						S								7		ental agre	•	c years (unaer ti	<u>c current</u>
,	TOTAL						**								,		intai agi t	cincit.			-
	8. List sepai	ately any am	ortization o	f lease exp	ense ir	ncluded on	page 4, line 34.									Fis	cal Year	Ending	An	nual Re	nt
	This amo	unt was calcu	lated by div	iding the t	otal a	mount to b	e amortized														
	by the lea	igth of the lea	ase		•											12.		/2002	\$		
																13.		/2003	\$		
	9. Option to	Buy:		YES		NO	Terms:				*					14.		/2004	\$		
	B. Equipmen	t-Excluding T	Fransportat	ion and Fi	xed Ec	quipment.	(See instructions.)														
		ble equipmen			ıilding	rental?				YES		NO									
	16. Rental A	mount for m	ovable equi	pment:	\$		Descript	ion:													
										(Attach a sc	nedul	e detailin	ig th	ie breakd	own o	t movable o	equipmen	t)			
	C. Vehicle Ro	ental (See inst	tructions.)																		
	1			2			3			4											
				lel Year			Monthly Lease			Rental Exp											
	Use		and	l Make			Payment			for this Pe	riod	,						s an option to			
17						\$		\$	<u> </u>				17					ovide compl	ete detai	ls on att	ached
18													18				schedule	•			
19													19				773.				
20													20					ount plus any			
21	TOTAL					\$		\$	3			1 2	21				expense	<u>must agree w</u>	ith page	4, line 3	<u>.4.</u>

XIII. EXPENSES RELATING TO VURSE AIDE TRAINING PROGRAMS (See instructions.) A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.) I. HAVE YOU TRAINED AIDES I. N YES I. HAVE YOU TRAINED AIDES IN YES II "yes", please complete the remainder of this schedule. If "no", provide an cyplanation as to why this training was not necessary. IN OTHER FACILITY II "yes", please complete the remainder of this schedule. If "no", provide an cyplanation as to why this training was not necessary. HOURS PER AIDE B. EXPENSES ALLOCATION OF COSTS (d) In the box below record the amount of ince Facility Drop-outs Completed Contract Total S S S S S S S S S S S S S												S	TATE OF ILLI	NOIS					Page 15
A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.) I. HAVE YOU TRAINED AIDES I. HAVE YOU TRAINED AIDES I. HAVE YOU TRAINED AIDES I. HOURS PROGRAM I. DURING THIS REPORT PERIOD? I. NO IN-HOUSE PROGRAM II. NOTHER FACILITY II. HOURS PROGRAM III. NOTHER FACILITY III. HOURS PRAIDE III. LOOMHELT LOOMHE III. HOURS PRAIDE III. HOURS PR														#	0011528	Report Period Beginning:	05/01/00	Ending:	04/30/01
1. HAVE YOU TRAINED AIDES X YES 2. CLASSROOM PORTION:	XIII. EX	PENSES	RELAT	ING TO) NUF	RSE AII	DE TRA	INING I	PROC	GRAMS (Se	ee ii	nstructions.)							
I. HAVE YOU TRAINED AIDES X YES 2. CLASSROOM PORTION: 3. CLINICAL PORTION:																			
I. HAVE YOU TRAINED AIDES X YES 2. CLASSROOM PORTION: 3. CLINICAL PORTION:	A. 7	TYPE OF	TRAIN	ING PR	OGR	AM (If	aides ar	e trainec	l in a	nother faci	lity	program, attach a	a schedule listing	g the faci	lity name, add	ress and cost per aide trained i	n that facility.	.)	
DURING THIS REPORT PERIOD? NO N-HOUSE PROGRAM IN OTHER FACILITY If "yes", please complete the remainder of this schedule, If "no", provide an explanation as to why this training was not necessary. B. EXPENSES ALLOCATION OF COSTS ALLOCATION OF COSTS I Community College Tuition I Community College Tuition I Completed Contract I Completed Contract I Completed Contract I Completed Contract I Total S S S S S S S S S S S S S																1			
PERIOP? NO N-HOUSE PROGRAM N-HOUSE PROGRA		1. HA	VE YOU	TRAIN	NED A	AIDES			X	YES	2.	CLASSROOM	PORTION:			3. CLINICAL PO	ORTION:		
IN OTHER FACILITY If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. HOURS PER AIDE ALLOCATION OF COSTS HOURS PER AIDE ALLOCATION OF COSTS (d) In the box below record the amount of ince facility received training aides from other I Facility Drop-outs Completed Contract Total S S S S S S S S S S S S S S S S S S S		DU	RING T	HIS RE	PORT	Γ													
IN OTHER FACILITY If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. B. EXPENSES ALLOCATION OF COSTS ALLOCATION		PEI	RIOD?							NO		IN-HOUSE PR	OGRAM			IN-HOUSE PR	ROGRAM		
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. B. EXPENSES ALLOCATION OF COSTS (d) ALLOCATION OF COSTS (d) In the box below record the amount of ince facility received training aides from other 1 facility received training received training aides from other 1 facility received training aides from ot																			
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. B. EXPENSES ALLOCATION OF COSTS (d) ALLOCATION OF COSTS (d) In the box below record the amount of ince facility received training aides from other 1												IN OTHER FA	CILITY	X		IN OTHER FA	CILITY	X	
of this schedule. If "no", provide an explanation as to why this training was not necessary. HOURS PER AIDE		If "	ves", ple	ease com	nlete 1	the rem	ainder												
explanation as to why this training was not necessary. HOURS PER AIDE								1			\Box	COMMUNITY	COLLEGE			HOURS PER	AIDE	40	
B, EXPENSES ALLOCATION OF COSTS (d) In the box below record the amount of ince Pacility Paci													COLLEGE			TO CITE I DIVI			
B. EXPENSES ALLOCATION OF COSTS (d) In the box below record the amount of ince facility received training aides from other 1 Pacility Drop-outs Completed Contract Total S Community College Tuition S S S S Books and Supplies S S S S Completed Contract Total S S Drop-outs Completed Contract Total S S Drop-outs S S S S S S S S S S S S S S S S S S S					J		8					HOURS PER	AIDE	84					_
ALLOCATION OF COSTS (d) In the box below record the amount of inco facility received training aides from other facility aides from other facilities from other facilities (f) received training aides from other facilities from other facilities from other facilities (f) received training aides from other facilities from other facilities from other facilities (f) received training aides from other facilities from other		1100	11000381	J•								TO CHO I EN I		34					
ALLOCATION OF COSTS (d)																			
ALLOCATION OF COSTS																			
In the box below record the amount of incompleted incomp	B. F	EXPENS	ES													C. CONTRACTUAL I	NCOME		
Community College Tuition S S S S S S S S S										ALLOCA	TIC	ON OF COSTS	(d)						
Facility Drop-outs Completed Contract Total S																			
Drop-outs Completed Contract Total S										1			3		4	facility receive	d training aid	es from othe	er facilities.
1 Community College Tuition											Fac	v							
2 Books and Supplies (a) 69 D. NUMBER OF AIDES TRAINED 3 Classroom Wages (a) 636 2,608 3,244 Clinical Wages (b) 824 824 COMPLETED 5 In-House Trainer Wages (c) 1. From this facility 6 Transportation 894 894 2. From other facilities (f) 7 Contractual Payments 757 3,130 3,887 DROP-OUTS 8 Nurse Aide Competency Tests 3350 1. From this facility 9 TOTALS \$ 1,393 \$ 7,875 \$ \$ 9,268 \$ 2. From other facilities (f) 10 SUM OF line 9, col. 1 and 2 (e) \$ 9,268 \$ TOTAL TRAINED (a) Include wages paid during the classroom portion of training. Do not include fringe benefits. (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8. (c) For in-house training programs only. Do not include fringe benefits. (f) Attach a schedule of the facility names and addresses										Drop-outs	3	Completed	Contract		Total	\$			
3 Classroom Wages (a) 636 2,608 3,244 Clinical Wages (b) 824 COMPLETED 5 In-House Trainer Wages (c) 1. From this facility Contractual Payments 757 3,130 3,887 DROP-OUTS 8 Nurse Aide Competency Tests 350 5,7875 S S 9,268 2. From other facilities (f) TOTAL TRAINED (e) S 9,268 TOTAL TRAINED (h) Include wages paid during the classroom portion of training. Do not include fringe benefits. (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8. (c) For in-house training programs only. Do not include fringe benefits. (f) Attach a schedule of the facility names and addresses	1	Comm	unity Co	llege Tu	ition				\$			\$	\$	\$					
4 Clinical Wages (b) 824 824 COMPLETED 5 In-House Trainer Wages (c) 1. From this facility 6 Transportation 894 894 2. From other facilities (f) 7 Contractual Payments 757 3,130 3,887 DROP-OUTS 8 Nurse Aide Competency Tests 350 350 1. From this facility 9 TOTALS \$ 1,393 \$ 7,875 \$ \$ 9,268 2. From other facilities (f) 10 SUM OF line 9, col. 1 and 2 (e) \$ 9,268	2	Books a	and Sup	plies								69			69	D. NUMBER OF AIDE	ES TRAINED		
5 In-House Trainer Wages (c)	3						(a)			636		2,608			3,244				
6 Transportation 894 894 2. From other facilities (f) 7 Contractual Payments 757 3,130 3,887 DROP-OUTS 8 Nurse Aide Competency Tests 350 1. From this facility 9 TOTALS \$ 1,393 \$ 7,875 \$ \$ 9,268 2. From other facilities (f) 10 SUM OF line 9, col. 1 and 2 (e) \$ 9,268 TOTAL TRAINED TOTAL TRAINED (a) Include wages paid during the classroom portion of training. Do not include fringe benefits. (e) The total amount of Drop-out and Completed Costs for 50 Include wages paid during the clinical portion of training. Do not include fringe benefits. (e) The total amount of Drop-out and Completed Costs for 50 Include wages paid during the clinical portion of training. Do not include fringe benefits. (f) Attach a schedule of the facility names and addresses (f) Attach a schedule of the facility n	4	Clinica	l Wages				(b)					824			824	COMPLE	TED		
7 Contractual Payments 757 3,130 3,887 DROP-OUTS 8 Nurse Aide Competency Tests 350 1. From this facility 9 TOTALS \$ 1,393 \$ 7,875 \$ \$ 9,268 2. From other facilities (f) 10 SUM OF line 9, col. 1 and 2 (e) \$ 9,268 TOTAL TRAINED (a) Include wages paid during the classroom portion of training. Do not include fringe benefits. (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8. (c) For in-house training programs only. Do not include fringe benefits. (f) Attach a schedule of the facility names and addresses	5	In-Hou	se Train	er Wage	es		(c)									1. From this fa	cility		
7 Contractual Payments 757 3,130 3,887 DROP-OUTS 8 Nurse Aide Competency Tests 350 1. From this facility 9 TOTALS \$ 1,393 \$ 7,875 \$ 9,268 2. From other facilities (f) 10 SUM OF line 9, col. 1 and 2 (e) \$ 9,268 TOTAL TRAINED (a) Include wages paid during the classroom portion of training. Do not include fringe benefits. (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8. (c) For in-house training programs only. Do not include fringe benefits. (f) Attach a schedule of the facility names and addresses	6	Transp	ortation									894			894	2. From other	facilities (f)		
8 Nurse Aide Competency Tests 9 TOTALS 9 TOTALS 1,393 \$ 7,875 \$ \$ 9,268 2. From other facilities (f) 10 SUM OF line 9, col. 1 and 2 (e) \$ 9,268 1 TOTAL TRAINED (a) Include wages paid during the classroom portion of training. Do not include fringe benefits. (b) Include wages paid during the clinical portion of training. Do not include fringe benefits. (c) For in-house training programs only. Do not include fringe benefits. (f) Attach a schedule of the facility names and addresses	7									757		3,130			3,887	DROP-OU	TS		
9 TOTALS S 1,393 S 7,875 S S 9,268 2. From other facilities (f) 10 SUM OF line 9, col. 1 and 2 (e) S 9,268 TOTAL TRAINED (a) Include wages paid during the classroom portion of training. Do not include fringe benefits. (b) Include wages paid during the clinical portion of training. Do not include fringe benefits. (c) For in-house training programs only. Do not include fringe benefits. (f) Attach a schedule of the facility names and addresses	8	Nurse A	Aide Cor	npetenc	y Test	ts									/				
10 SUM OF line 9, col. 1 and 2 (e) \$ 9,268 TOTAL TRAINED (a) Include wages paid during the classroom portion of training. Do not include fringe benefits. (b) Include wages paid during the clinical portion of training. Do not include fringe benefits. (c) For in-house training programs only. Do not include fringe benefits. (f) Attach a schedule of the facility names and addresses	9								\$	1,393			\$	\$	9,268				
(a) Include wages paid during the classroom portion of training. Do not include fringe benefits. (b) Include wages paid during the clinical portion of training. Do not include fringe benefits. (c) For in-house training programs only. Do not include fringe benefits. (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8. (f) Attach a schedule of the facility names and addresses	10	SUM C	F line 9	col 1 a	nd 2		(e)		S			Í			Í	TOTALTI	RAINED		
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits. (c) For in-house training programs only. Do not include fringe benefits. (d) Vyour own aides must agree with Sch. V, line 13, col. 8. (e) For in-house training programs only. Do not include fringe benefits. (f) Attach a schedule of the facility names and addresses	10	30111	, init),	, con 1 a	u #		(0)		Ψ	7,200	\vdash					TOTAL II			
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits. (c) For in-house training programs only. Do not include fringe benefits. (d) Vyour own aides must agree with Sch. V, line 13, col. 8. (e) For in-house training programs only. Do not include fringe benefits. (f) Attach a schedule of the facility names and addresses																			
(c) For in-house training programs only. Do not include fringe benefits. (f) Attach a schedule of the facility names and addresses																			
		(b) Incl	lude wag	es paid	during	g the cli	nical po	rtion of t	traini	ng. Do not	inc	lude fringe benefi	ts.		your own a	aides must agree with Sch. V, li	ne 13, col. 8.		
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in of those facilities for which you trained aides.												ed to be trained in			of those fa	cilities for which you trained ai	des.		
your facility. Drop-out costs can only be for costs incurred by your own aides.																			

							STATE OF II					Page 16	
Faci	lity Name & ID Number	MEADOW	MANOR				# 0011528	Report Period Bo	eginning:	05/01/00	Ending:	04/30/01	
XI	V. SPECIAL SERVICES (Di	rect Cost) (S	See instructions.)			_				_		_	
			1		2	3	4	5	6	7		8	
			Schedule V		Sta			de Practitioner	Supplies				
	Service		Line & Column		nits of	Cost	_ \	han consultant)	(Actual or)	Total Units		otal Cost	
			Reference	Se	rvice		Units	Cost	Allocated)	(Column 2 + 4)	(Col	1.3 + 5 + 6	
1	Licensed Occupational Ther	_			hrs	\$		\$	\$		\$		1
	Licensed Speech and Langu	age											
2	Development Therapist				hrs								2
3	Licensed Recreational Thera	•			hrs								3
4	Licensed Physical Therapist	t			hrs								4
5	Physician Care				visits								5
6	Dental Care				visits								6
7	Work Related Program				hrs								7
8	Habilitation				hrs								8
					# of								
9	Pharmacy				prescrpts								9
	Psychological Services												
	(Evaluation and Diagnosis/												
10	Behavior Modification)				hrs								10
11	Academic Education				hrs								11
12	Exceptional Care Program												12
13	Other (specify): OXYGEN	1	39 - 5						5,135			5,135	13
14	TOTAL		-			\$		\$	\$ 5,135		\$	5,135	14
NO	ΓE: This schedule should inclu												
	Schedule XVIII-B. Salarie	es of unlicens	ed practitioners, su	ch as nur	se aides, who	help with the abo	ve activities sh	ould not be listed					
	on this schedule.												

						STAT	E OF ILLIN	OIS					Page 17	
Faci	lity Name & ID Number MEADOW MAN	OR				#	0011528		Report Period Beginning: 05/01/00		Ending:		04/30/01	
	XV. BALANCE SHEET - Unrestricted Opera					As of	04/30/01		(last day of reporting year)					
	This report must be completed eve	n if	financial stateme	nts	are attached.									
			1		2 After					1			2 After	
			Operating		Consolidation*	•				(Operating		Consolidation*	
	A. Current Assets								C. Current Liabilities					
1	Cash on Hand and in Banks	\$	27,527	\$		1		26	Accounts Payable	\$	54,364	\$		26
2	Cash-Patient Deposits					2		27	Officer's Accounts Payable					27
	Accounts & Short-Term Notes Receivable-							28	Accounts Payable-Patient Deposits					28
3	Patients (less allowance)	124,443			3		29	Short-Term Notes Payable					29
4	Supply Inventory (priced at)				4		30	Accrued Salaries Payable		27,965			30
5	Short-Term Investments					5			Accrued Taxes Payable					
6	Prepaid Insurance		33,672			6		31	(excluding real estate taxes)		14,443			31
7	Other Prepaid Expenses					7		32	Accrued Real Estate Taxes(Sch.IX-B)		37,924			32
8	Accounts Receivable (owners or related parties)					8		33	Accrued Interest Payable					33
9	Other(specify):					9		34	Deferred Compensation					34
	TOTAL Current Assets							35	Federal and State Income Taxes		243			35
10	(sum of lines 1 thru 9)	\$	185,642	\$		10			Other Current Liabilities(specify):					
	B. Long-Term Assets		,					36						36
11	Long-Term Notes Receivable			Т		11		37						37
12	Long-Term Investments					12			TOTAL Current Liabilities					
13	Land		43,077			13		38	(sum of lines 26 thru 37)	\$	134,939	\$		38
14	Buildings, at Historical Cost		1,088,360			14			D. Long-Term Liabilities		,			
15	Leasehold Improvements, at Historical Cost		423,720			15		39	Long-Term Notes Payable		289,726			39
16	Equipment, at Historical Cost		,			16		40			,			40
17	Accumulated Depreciation (book methods)		(1,312,146)			17		41						41
18	Deferred Charges		()-) -)			18		42	3					42
19	Organization & Pre-Operating Costs					19			Other Long-Term Liabilities(specify):					
	Accumulated Amortization -							43	() i i i i i i i i i i i i i i i i i i	T				43
20	Organization & Pre-Operating Costs					20		44						44
21	Restricted Funds					21			TOTAL Long-Term Liabilities					
22	Other Long-Term Assets (specify):					22		45	<u> </u>	\$	289,726	\$		45
23	Other(specify):	+		-		23			TOTAL LIABILITIES	Ť				1.0
	TOTAL Long-Term Assets	+		-				46		\$	424,665	S		46
24	(sum of lines 11 thru 23)	\$	243,011	\$		24	,	-10	(Sum of lines of and 45)	Ψ	121,003	Ψ		10
27	(Sum of files 11 till 420)	Φ	273,011	Ф		27		47	TOTAL EQUITY(page 18, line 24)	\$	3,988	\$		47
<u> </u>	TOTAL ASSETS		+	-					TOTAL LIABILITIES AND EQUITY		3,700	Ф		+ * /
25	(sum of lines 10 and 24)	•	428,653	\$		25		48		\$	428,653	\$		48
43	(sum of fines to and 24)	Φ	420,033	Φ		23		40	(sum of fines 40 and 47)	Φ	420,033	Φ		70
		\dashv				*(See	instructions.)						

				STATE OF ILLIN	O	IS			Page 18
Facility Name & ID Number N			#	0011528	F	Report Period Beginning	: 05/01/00	Ending:	04/30/01
XVI. STATEMENT OF	T CH	IANGES IN EQUITY							
				1					
				Total					
	1	Balance at Beginning of Year, as Previously Reported	\$	98,132		1			
	2	Restatements (describe):				2			
	3					3			
	4					4			
	5					5			
	6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	98,132		6			
		A. Additions (deductions):							
	7	NET Income (Loss) (from page 19, line 43)		(94,144)		7			
	8	Aquisitions of Pooled Companies				8			
	9	Proceeds from Sale of Stock				9			
	10	Stock Options Exercised				10			
	11	Contributions and Grants				11			
	12	Expenditures for Specific Purposes				12			
	13	Dividends Paid or Other Distributions to Owners	())	13			
	14	Donated Property, Plant, and Equipment				14			
	15	Other (describe)				15			
	16	Other (describe)				16			
	17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	(94,144)		17			
		B. Transfers (Itemize):							
	18		П		Т	18			
	19					19			
	20					20			
	21					21			
	22					22			
	23	TOTAL Transfers (sum of lines 18-22)	\$			23			
		BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	3,988	_	24 *			
<u> </u>		DIETH (Sum of mes o + 17 + 20)	Ψ	2,500					
				* This must agree	wit	th page 17, line 47.			
				9					

		П			TE OF ILLI	NOI	8		Page 19	
Facility Name & ID	Number MEADOW MANOR			#	0011528		Report Period Beginning: 05/01/00	Ending:	04/30/01	
	IE STATEMENT (attach any explanatory									
	ations of revenue and expense must be pro									
Note: T	his schedule should show gross rêve	nue	and expenses	. Do	not net rev	enue	against expense.			
			1						2	
Reven			Amount				Expenses		Amount	
A. Inpatient (A. Operating Expenses			
	e All Levels of Care	\$	1,931,958	1			General Services		509,004	31
	Allowances for all Levels	()	2		32	Health Care		872,641	32
3 SUBTOTAL I	npatient Care (line 1 minus line 2)	\$	1,931,958	3		33	General Administration		512,465	33
B. Ancillary I	Revenue						B. Capital Expense			
4 Day Care				4		34	Ownership		71,856	34
5 Other Care for	Outpatients			5			C. Ancillary Expense			
6 Therapy				6		35	Special Cost Centers			35
7 Oxygen			5,135	7		36	Provider Participation Fee		82,125	36
8 SUBTOTAL	Ancillary Revenue (lines 4 thru 7)	\$	5,135	8			D. Other Expenses (specify):			
	erating Revenue		-,			37	La Capacita (April 1997)			37
9 Payments for				9		38				38
10 Other Governi				10		39				39
11 Nurses Aide T	raining Reimbursements		6,441	11						
12 Gift and Coffe				12		40	TOTAL EXPENSES (sum of lines 31 thru 39	9)*	\$ 2,048,091	40
13 Barber and Be	auty Care			13						
14 Non-Patient M	2			14		41	Income before Income Taxes (line 30 minus)	line 40)**	(94,144)	41
15 Telephone, Te	levision and Radio			15				,	, ,	_
16 Rental of Faci			4,200	16		42	Income Taxes			42
17 Sale of Drugs	,		,	17						_
18 Sale of Suppli	es to Non-Patients			18		43	NET INCOME OR LOSS FOR THE YEAR	(line 41 minus line 42)	\$ (94,144)	43
19 Laboratory				19	-			,	, , ,	+
20 Radiology and	X-Ray			20						_
21 Other Medical				21						-
22 Laundry			1,125	22						-
	Other Operating Revenue (lines 9 thru 22)	2 (11,766	23						-
D. Non-Opera		<i>γ</i> Φ	11,700							_
24 Contributions	ating Revenue			24	,	*	This must agree with page 4, line 45, column	4.		_
	ther Investment Income***		1,833	25			ig. co page 1, and 10, column			+
	Non-Operating Revenue (lines 24 and 25)	s	1,833	26	,	**	Does this agree with taxable income (loss) pe	r Federal Income		+
	enue (specify):****	Ψ	1,033	20				attach a reconciliation.		-
27 Settlement	Income (Insurance, Legal, Etc.)			27			i and in the piease	actach a reconcination.		+
	2,053 ADMIT FEES \$750	++	2,803	28		***	See the instructions. If this total amount has	not been offset		-
	Debt Recovery \$370 Old Checks \$20	+	452	28a			against interest expense on Schedule V, line 3			+
	Other Revenue (lines 27, 28 and 28a)	©.	3,255	29			detailed explanation.	2, picase menue a		+
27 SUBTUTAL C	other Revenue (inies 27, 20 and 20a)	Ф	3,433	29			истанси ехрганацон.			+
30 TOTAL REV	ENUE (sum of lines 3, 8, 23, 26 and 29)	\$	1,953,947	30	,	****	Provide a detailed breakdown of "Other Rev	enue" on an attached she	eet.	

					STATE OF	FILLINOIS				Page 20	1
Facility Name & ID Number MEA	DOW MANOR			#	0011528	Report Peri	od Beginning:	05/01/00	Ending:	04/30/01	
XVIII. A. STAFFING AND SALARY	COSTS (Please ro	eport each line	separately.)								
(This schedule must cover the	entire reporting	period.)				B. CONSULTANT SER	VICES				
	1	2**	3	4				1	2	3	
	# of Hrs.	# of Hrs.	Reporting Period	Average				Number	Total Consultant	Schedule V	1
	Actually	Paid and	Total Salaries,	Hourly				of Hrs.	Cost for	Line &	
	Worked	Accrued	Wages	Wage				Paid &	Reporting	Column	
1 Director of Nursing	2,000	2,080	\$ 43,147	\$ 20.74	1			Accrued	Period	Reference	
2 Assistant Director of Nursing	1,300	1,372	22,918	16.70	2	35 Dietary Consultant	t	192	\$ 3,481	1 - 3	35
3 Registered Nurses	3,899	3,974	68,969	17.36	3	36 Medical Director		240	12,000	9 - 3	36
4 Licensed Practical Nurses	21,833	22,848	288,763	12.64	4	37 Medical Records C	Consultant	17	485	10 - 3	37
5 Nurse Aides & Orderlies	40,954	42,068	331,394	7.88	5	38 Nurse Consultant		8	1,427	10 - 3	38
6 Nurse Aide Trainees	790	790	4,068	5.15	6	39 Pharmacist Consul	ltant	48	1,200	10 - 3	39
7 Licensed Therapist			7		7	40 Physical Therapy (Consultant		, , , , ,		40
8 Rehab/Therapy Aides	1,883	1,958	16,780	8.57	8	41 Occupational Ther					41
9 Activity Director	1,977	1,993	11,720	5.88	9	42 Respiratory Thera	py Consultant				42
10 Activity Assistants	1,775	1,810	9,534	5.27	10	43 Speech Therapy Co	onsultant				43
11 Social Service Workers	1,808	1,885	18,710	9.93	11	44 Activity Consultant					44
12 Dietician	1,000	1,000	10,710	7.50	12	45 Social Service Cons		42	2,396	12 - 3	45
13 Food Service Supervisor	2,025	2,276	24,386	10.71	13	46 Other(specify)	Suitant	12	2,570	12 0	46
14 Head Cook	2,023	2,270	24,500	10.71	14	47 ADMINISTRATIV	/E.CONSULTANT	340	8,132	17 - 3	47
15 Cook Helpers/Assistants	12,898	13,431	86,284	6.42	15	48	E CONSCETATO	540	0,102	17 5	48
16 Dishwashers	12,000	10,101	00,204	0.12	16	10					10
17 Maintenance Workers	5,267	5,430	38,111	7.02	17	49 TOTAL (lines 35 -	48)	887	\$ 29,121		49
18 Housekeepers	6,698	6,847	37,368	5.46	18	15 TOTAL (mies ce	10)	007	2>,121		 •
19 Laundry	4,077	4,220	24,691	5.85	19						+
20 Administrator	2,000	2,080	49,631	23.86	20						+
21 Assistant Administrator	2,000	2,000	47,001	25.00	21	C. CONTRACT NURSE	es es				+
22 Other Administrative					22	e. commuter weather	25	1	2	3	+
23 Office Manager					23			Number	-	Schedule V	+
24 Clerical	2,733	2,800	17,280	6.17	24			of Hrs.	Total	Line &	+
25 Vocational Instruction	2,733	2,000	17,200	0.17	25			Paid &	Contract	Column	+
26 Academic Instruction					26			Accrued	Wages	Reference	+
27 Medical Director					27	50 Registered Nurses		Acciucu	\$	Reference	50
28 Qualified MR Prof. (QMRP)					28	51 Licensed Practical	Nurses		3		51
29 Resident Services Coordinator					29	52 Nurse Aides	11u1scs				52
30 Habilitation Aides (DD Homes)					30	32 Ivarse Alues					32
31 Medical Records					31	53 TOTAL (lines 50 -	52)		S		53
32 Other Health Care(specify)					32	33 101AL (IIIIes 50 -	34)		٩		33
33 Other(specify) Utility Workers	2,579	2,590	13,724	5.30	33						+
34 TOTAL (lines 1 - 33)	116,496		\$ 1,107,478 *	\$ 9.19	34						+
34 101AL (lines 1 - 33)	110,490	120,452	3 1,10/,4/8	\$ 9.19	34						+
* This total must agree with page 4,	column 1, line 45.		** See instructions	s.							

					STATE OF	ILI	LINOIS				P	age 21
Facility Name & ID Number	MEADOW MANO	R			# 0011528		R	epo	rt Period Begi	nning: 05/01/00 1	Ending:	
XIX. SUPPORT SCHEDULES						T		Ť			Ĭ	
A. Administrative Salaries		Ownershi	р		D. Employee Benefits and Payroll	Ta	xes			F. Dues, Fees, Subscriptions and Pr	romotio	ns
Name	Function	%	1	Amount	Description				Amount	Description		Amount
RONALD DALLSTREAM	ADMINISTRATOR	0	\$	49,631	Workers' Compensation Insurance	ee		\$	53,434	IDPH License Fee		\$ 200
					Unemployment Compensation Ins	ura	ance		11,653	Advertising: Employee Recruitmen	ıt	4,571
					FICA Taxes				83,426	Health Care Worker Background	Check	630
					Employee Health Insurance					(Indicate # of checks performed	53)	
					Employee Meals					SEE ATTACHED SCHEDULE		5,343
					Illinois Municipal Retirement Fun	ıd (IMRF)*					
					HBV VACCINE	T			(8)	NURSING HOME MANAGERS A	LLOC.	65
TOTAL (agree to Schedule V, lin	ne 17, col. 1)				SECTION 125 PLAN				24,442			
(List each licensed administrator	· separately.)		\$	49,631	EMPLOYEE LIFE INSURANCE				2,284			
B. Administrative - Other					GIFT CERTIFICATES				1,380	Less: Non-allowable Dues		(60
					EMPLOYEE PARTY & APPREC	'IA'	ΓΙΟΝ		550	Less: Public Relations Expense		(4,013
Description				Amount						Non-allowable advertising		(
ADMINISTRATIVE CONSULT	CANT		\$	8,132	NURSING HOME MANAGERS A	\LI	LOCATION	N	10,086	Yellow page advertising		(847
										1 0		
					TOTAL (agree to Schedule V,			\$	187,247	TOTAL (agree to Sch.	V,	\$ 5,895
					line 22, col.8)					line 20, col. 8)	-	
TOTAL (agree to Schedule V, lin	ne 17, col. 3)		\$	8,132	E. Schedule of Non-Cash Compens	sati	ion Paid			G. Schedule of Travel and Seminar	**	
(Attach a copy of any manageme	,	ıt)		-	to Owners or Employees							
C. Professional Services										Description		Amount
Vendor/Payee	Type			Amount	Description]	Line#		Amount	•		
NURSING HOME MANAGERS		NT	\$	154,557	HVB VACCINE		22	\$	(8)	Out-of-State Travel		\$
CSC	CORP. REPRI	ESENTATIO	N	463	GIFT CERTIFICATES		22		1,380			
					EMPLOYEE PARTY & APPREC		22		550			
										In-State Travel		
										Administrator Mileage Reimbursen	nent	525
						T				Miscellaneous Mileage Reimbursen		201
						T				Nursing Home Managers Allocation		1,414
						_				Seminar Expense		2,11
						-						
						\dashv						
						+		+				
			1			+				Entertainment Expense		(
TOTAL (agree to Schedule V, lin	ne 19. column 3)		1		TOTAL	\dashv		\$	1,922	(agree to Sch. V,		
(If total legal fees exceed \$2500 a		es.)	S	155,020				*	1,>22	TOTAL line 24, col. 8)		\$ 2,140
(11 total legal lees exceed \$2500 a	copy of invoice		ψ	155,020	* Attach copy of IMRF notification	16				**See instructions.		Ψ 2,170
				1	1 LUCIO COPT OF LIVING HOURICALION	417		1			1	1

								STATE O	F IL	LINOIS									Page 22
Facil	ity Name & ID Number	MEADOW MAI	NOR					#		0011528				Report Perio	d Beginnin	g:	05/01/00	Ending:	04/30/01
					~														
XIX-	H. SUPPORT SCHEDULE	C - DEFERRED I	MAINTENAI	NCE CO	STS	S (which have	e be	en included	l in S	Sch. V, lin	ie (6, col. 3).							
	(See instructions.)	2	3	4		5		6		7		8		9	10		11	12	13
	1	Month & Year	3	-		3		U				_	Ex	pense Amorti	-	ar	11	12	13
	Improvement	Improvement	Total Cost	Use	ful											<u> </u>			
	Туре	Was Made		Lif	fe	FY1998		FY1999		FY2000		FY2001		FY2002	FY2003		FY2004	FY2005	FY2006
1	PAINTING	VARIOUS	\$ 4,140	36 N	O	\$	\$		\$			\$	\$		\$		\$	\$	\$
2	PAINTING	VARIOUS	2,260	36 N	0														
3	PAINTING	VARIOUS	2,090	36 N	Ю														
4	PAINTING	VARIOUS	1,690	36 N	Ю														
5	PAINT & WALLPAPER	VARIOUS	4,650	36 N	Ю														
6	PAINT & WALLPAPER	VARIOUS	3,255	36 N	10	542													
7	PAINT & WALLPAPER	10/95	3,414	36 N	10	1,138		569											
8	PAINT & WALLPAPER	5/96 - 4/97	5,617	36 N	0	1,872		1,872		937									
9	PAINT & WALLPAPER	5/97 - 4/98	2,685	36 N	0	448		895		895		447							
10																			
11																			
12																			
13																			
14																			
15																			
16																			
17																			
18																			
19																			
20	TOTALS		\$ 29,801			\$ 4,000	\$	3,336	\$	1,832		\$ 447	\$		\$		\$	\$	\$

								ST	ATE (OF ILLINOIS					Page 23
	Name & ID Nu			OW MANOR					#	0011528	Report Period Begin	ning:	05/01/00	Ending:	04/30/01
	NERAL INFO														
(1)	Are nursing emp	oloyees (RN,LPN	,NA) represented by	a union?	NO			(13)	Have costs for all suppli					
										the Department of Publi			te, been prope	rly classified	
					ided on the cost repo	rt?	NO			in the Ancillary Section	of Schedule V?	YES			
	If YES, give ass	ociation	name an	d amount.											
									(14)	Is a portion of the buildi			nan long term	care services	for
					payments to a politic					the patient census listed				For example	
	action organizat		NO		If YES, have these	costs				is a portion of the buildi	ng used for rental, a pl	armacy, c	day care, etc.)	If YES, attac	h
	been properly ac	ljusted o	ut of the	cost report?						a schedule which explai	ns how all related costs	s were allo	ocated to these	functions.	
					number of beds licer		he		(15)	Indicate the cost of emp					
	end of the fiscal	year?	NO	If YES,	what is the capacity	?				on Schedule V. \$			neal income b		ainst
										related costs?	NO	Indicate t	he amount. \$		
					quipment purchases?		YES								
	What was the av	erage lif	e used fo	r new equipment ad	ded during this perio	od?	10		(16)	Travel and Transportation	on				
										a. Are there costs includ		el?	NO		
					disposable diaper ex	pense				If YES, attach a comp					
	and the location	of this e	xpense o	n Sch. V. \$	823	Line	10			b. Do you have a separa					
]				residents? NO	If YES, please indi	cate the ar	mount of inco	me earned fro	m such a
					using accounting pro					program during this re	eporting period. \$				
	consistent with p	orior repo	orts?	YES If NO, a	ttach a complete exp	olanatio	n.			c. What percent of all tra	avel expense relates to	transporta	ation of nurses	and patients?	? 0
										d. Have vehicle usage lo	gs been maintained?	N/A			
				r a sale and leasebac	k arrangement?	NO				e. Are all vehicles stored		luring the	night and all	other	
	If YES, give effe	ective da	te of leas	se.						times when not in use					
										f. Has the cost for comm		l use of au	itos been adju	sted	
(9)	Are you present	ly operat	ing unde	r a sublease agreem	ent?	YES	X	NO		out of the cost report?					
										g. Does the facility tr	ansport residents to	and fro	m day train	ing?	NO
(10)	Was this home p	reviousl	y operate		(as is defined in the						nt of income earned		oviding suc	h	
	Schedule VII)?			NO X	If YES, please indic	cate nar	ne of the fac	cility,		transportation du	ring this reporting p	eriod.	\$		
	IDPH license nu	mber of	this relat	ed party and the dat	e the present owners	took o	ver.								
									(17)	Has an audit been perfor	rmed by an independer	t certified	l public accou	nting firm?	NO
										Firm Name:				The instruct	
					s paid and accrued to	the De	partment			cost report require that a	copy of this audit be i	ncluded v	vith the cost re	port. Has this	s copy
	of Public Aid du	ring this	cost rep	ort period. \$	82,125					been attached?	If no, please exp	olain.			
	This amount is t	o be reco	orded on	line 42 of Schedule	V.										
									(18)	Have all costs which do	not relate to the provis	sion of lon	g term care be	en adjusted o	out
(12)					to more than one line					out of Schedule V?	YES				
	for an individual	employ	ee?	YES If YES,	attach an explanatio	n of the	allocation.								
									(19)	If total legal fees are in	excess of \$2500, have	legal invo	ices and a sun	mary of servi	ices
										performed been attached		N/A			
										Attach invoices and a su	immary of services for	all archite	ect and apprais	sal fees.	

MEADOW MANOR			#	0011528			05/01/00	- 04/30/01	PAGE 24
SCHEDULE V - PAGES 3	3 & 4								
LINE 27 - OTHER GENE			NI.						
LINE 21 - OTHER GENE	RAL ADIVI	INISTRATIO	'IN						
BAD DEBTS			\$	4,794					
SALES TAX				2,998					
FINES				7,215					
ILLINOIS RT TAX				243					
LINE 27 - COLUMN 3			\$	15,250					
COLUMN E DETAIL OF		CIFICATION	0						
COLUMN 5 - DETAIL OF	- RECLAS	SIFICATION	5	AMOUNT	LINE	= #			
FROM: OXYGEN			\$		10	- #			
TROM: OXTOLIV			Ψ	(0,100)	10				
TO: ANCILLARY SER	RVICES		\$	5,135	39				
10. AUTOILLAUTT OLA	WIOLO		Ψ	0,100	00				
TO: ADMINISTRATIVE			AGI\$		17				
NURSE CONULT.	ANT MILE	AGE		28	10				
FROM: TRAVEL			\$	(889)	24				

MEA	DOW MANC	R		0011528		05/01/00	- 04/30/01			PAGE 25	
PAG	E 6 - SCHE	DULE VII -	PART A -	COLUMN 1	P	AGE 13 - SCH	EDULE XI - SECTION	ON E			
		DT\(*\LED0			DECOMOUNT	TION OF BERREAL	TION			
F	RELATED PA	KIY - OW	NERS	OWNEDCHIE 0/		RECONCILIA	TION OF DEPRECIA	ATION			
	LL DAYAG			OWNERSHIP %		00115011153	(I OFOTION F I	INIT 40	00.070		
		OND KLEIN		37.01923			(I - SECTION E - L		29,670		
	SAM KLEI			44.80769		NURSING HO	ME MANAGERS AL	LOCATION	1,733		
	GERDA H			3.65385							
		& MARY DE	EL VALLE	6.73077		SCHEDULE \	/ - LINE 30 - COLU	JMN 8 \$	31,403		
	PHILIP KL			1.73077							
	DANA KLE	ΞIN		1.73077							
	LISA GILD)AR		1.73077							
	ALYCE KL	EIN		<u>2.59615</u>							
				100							
PAG	E 15 - SCH	EDULE XII									
. / (0											
Т	RAINED AT:	SUNRISE		F VIRDEN, INC.							
 '			H WRIGHT								
		VIRDEN, I		OIVI U.							
		VIIXDLIN, I	L 02010								
	COST PER A	IDE TRAINI	 =D: 4 @ ¢:	782 50							
	JOST I LIX A		_b. ¬ @ v	102.00							

MEADOW MANOR #	0011528		05/01/00	-	04/30/01				PAGE 26
PAGE 19 - SCHEDULE XVII				DΛ	CE 21 S	CHEDULE XIX -	SEC	TION E	
RECONCILIATION OF INCOME				ГА		ES, SUBSCRIPTI			POMOTIONS
NEGONOIEIATION OF INCOME					DOLO, I L	Lo, oobookii Ti		, AND I I	COMOTIONS
LINE 43 - NET INCOME \$	(94,144)				YELLOW I	PAGES	\$	847	
*MANAGEMENT FEE 4/00	(13,172)				PUBLIC R	ELATIONS		4,013	
*MANAGEMENT FEE 4/01	11,516				OPTIMIST	CLUB DUES		60	
INTEREST INCOME	(1,833)				BOILER L	ICENSE		100	
RENTAL INCOME	(4,600)				FRANCHIS	SE FEES		323	
							\$	5,343	
TAXABLE INCOME \$	(102,233)								
* RELATED PARTY ACCOUNTS									
FOR TAX PURPOSES ARE INC									
WITH PRIOR YEAR COST REPO	DRIS AND TO CONFO	RW WITH							
ACCOUNTING METHODS.									
PAGE 23 - SCHEDULE XX									
QUESTION #12									
SALARY COSTS ARE ALLOCAT	ED TO DEPARTMENT								
BASED UPON HOURS WORKE	O PER TIME CARDS.								

CENTRAL OFFICE (COST ALLO	CA ⁻	TION											
MEADOW MANOR		#	‡	0011528		PAGE 27		05/01/00	TO	04/30/01				
SCHEDULE VII PAG	F 6 LINE 2	2	•											
OGNEDOLL VII 1710	1	<u> </u>												
CENTRAL OFFICE (COST ALLO	CA ⁻	TION											
MEADOW MANOR		Ē												
2000		Ħ												
2000														
													2000	REFRNC
	MAY 00	111	JULY	AUG	SEPT	OCT	NOV	DEC	JAN 01	FEB	MARCH	APRIL	TOTAL	NUMBER
	1017(1 00	٠.	UOLI	7,00	OLI I	001	140 V	DLO	0711101	1 20	W/ (TOTT	ATTAL	TOTAL	NOWIDER
SALARIES-ADMIN	\$2,876	#	\$2,838	\$2,158	\$2,092	\$1,993	\$1,921	\$1,986	\$2,617	\$2,477	\$2,471	\$2,381	\$28,655	17
SALARIES-CLERIC	1,475		1,456	1,138	1,104	1.052	1,013	1.048	1,381	1,307	1,303	1,256	14,992	21
SALARIES-ACTIV	.,		,	,	, 1	,	,	,	,	,	,	,	,,	
SALARIES-NURSE									208	197	196	189	789	10
ACCOUNTING	9	#	9	10	10	9	9	9	8	8	8	8	108	19
WORK COMP INS	15		15	27	26	25	24	25	27	25	25	24	274	22
SUPPLIES	140	#	138	42	40	38	37	38	104	98	98	94	1,006	21
TELEPHONE	67		66	106	102	98	94	97	63	60	59	57	934	21
EMPL BENEFITS	475	#	469	569	552	526	507	524	506	479	478	461	6,016	22
PAYROLL TAXES	354		349	307	298	284	273	283	342	324	323	311	3,796	22
TRAVEL	203	#	200	241	234	223	215	222	82	77	77	74	2,050	24
IN SERVICE	14	#	14	5	4	4	4	4	4	4	4	4	77	23
MEDICAL CONSULT	Γ													
MACHINE RENTAL	22		22						17	16	16	15	129	6
OWNERS COMP	337		333	346	335	319	308	318	303	287	286	276	3,781	17
INS-PROP,LIAB,WC			24	32	31	30	29	30	32	30	30	29	346	26
DEPRECIATION	157		155	156	151	144	139	144	140	133	132	128	1,733	30
RENT	347		342	346	335	320	308	318	319	302	302	291	3,873	34
MAINTENANCE	28		28	52	51	48	47	48	51	49	49	47	525	6
FEES & PUBLICAT		#	5	5	5	5	5	5	5	4	4	4	57	20
ADVERTISING	3	#	3										8	20
T0T41		<u></u> -					<u> </u>							
TOTAL	\$6,552	-	\$6,465	\$5,540	\$5,371	\$5,117	\$4,932	\$5,099	\$6,208	\$5,876	\$5,861	\$5,649	\$69,149	
	======	= = =		======	======	======	======	======	======	======	======	======	=======	
FIXED ASSETS													69,149	
EQUIP - PRIOR	9,388		9,262	9,364	9,078	8,651	8,337	8,620	11,675	11,051	11,023	10,624	9,697	
EQUIP - CURR	4,322		4,264	4,311	4,180	3,983	3,838	3,969	4.07:	4.504	4 500	263	2,784	
EQUIP - FULLY DEF			1,133	1,145	1,110	1,058	1,019	1,054	1,674	1,584	1,580	1,523	1,264	
BLDG - PRIOR	1,375	#	1,357	1,372	1,330	1,267	1,221	1,263	1,235	1,169	1,166	1,124	1,270	
BLDG - CURR														
BLDG - FULLY DEP	1													

MEADOW		NIAGES	JSED ON F	##	0011528		PAGE 29		05/01/00	04/30/0
				,,	0011020		1710E 20		00/01/00	0 11 0 01 0
OCCUPIE										
DAYS	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL		
2000	DADIN		OTILLL	IIIL III		METO II IE	001111102	101712		
JANUARY	2453	1828	2186	1874	663	1482	2008	12494		
FEBRUAR	2205	1686	2168	1746	597	1442	1996	11840		
MARCH	2383	1773	2434	1904	604	1569	2285	12952		
APRIL	2273	1671	2387	1783	641	1496	2155	12406		
MAY JUNE	2301 2211	1691 1730	2252 2175	1910 1793	600 603	1448 1426	2073 1906	12275 11844		
JULY	2317	1823	2396	1846	652	1459	1889	12382		
AUGUST	2249	1817	2342	1861	673	1516	1966	12424		
SEPTEM	2163	1790	2174	1709	665	1606	1899	12006		
OCTOBER	2249	1815	2246	1709	627	1766	1986	12398		
NOVEMBE	2288	1675	2189	1590	594	1689	2002	12027		
DECEMBE	2294	1678	2228	1642	668	1664	2130	12304		
TOTAL	27386	20977	27177	21367	7587	18563	24295	147352		1
								147352		
ALLOCATI	ON									
PERCENT		D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL		
2000										
JANUARY		19.63%	14.63%	17.50%	20.31%	11.86%	16.07%	100.00%		
FEBRUAR	Υ	18.62%	14.24%	18.31%	19.79%	12.18%	16.86%	100.00%		
MARCH		18.40%	13.69%	18.79%	19.36%	12.11%	17.64%	100.00%		
APRIL		18.32%	13.47%	19.24%	19.54%	12.06%	17.37%	100.00%		
MAY		18.75%	13.78%	18.35%	20.45%	11.80%	16.89%	100.00%		
JUNE		18.67%	14.61%	18.36%	20.23%	12.04%	16.09%	100.00%		
JULY AUGUST		18.71% 18.10%	14.72% 14.62%	19.35% 18.85%	20.17%	11.78% 12.20%	15.26% 15.82%	100.00%		
SEPTEMB	FR	18.02%	14.91%	18.11%	19.77%	13.38%	15.82%	100.00%		
OCTOBER		18.14%	14.64%	18.12%	18.84%	14.24%	16.02%	100.00%		
NOVEMBE		19.02%	13.93%	18.20%	18.16%	14.04%	16.65%	100.00%		
DECEMBE		18.64%	13.64%	18.11%	18.77%	13.52%	17.31%	100.00%		
OCCUPIE	,									
DAYS	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENADO	SUNRISE	TOTAL		
2001	DADR	пшт	JVILLE	INIEAD IVI	IVIIVIVV	WENARD	SUINKISE	TOTAL		
JANUARY	2,278	1,698	2,136	1,630	595	1,701	2,074	12,112		
FEBRUAR	2,100	1,570	2,130	1,408	518	1,538	1,875	11,076		
MARCH	2,277	1,656	2,349	1,605	558	1,660	2,366	12,471		
APRIL	2,198	1,578	2,311	1,461	560	1,563	2,419	12,090		
MAY	2,210	1,727	2,404	1,535	543	1,568	2,491	12,478		
JUNE	2,141	1,615	2,368	1,691	304	1,673	2,417	12,209		
JULY	2,114	1,602	2,434	2,119		1,702	2,441	12,412		
AUGUST										
SEPTEM										-
OCTOBER										
NOVEMBE DECEMBE										-
JEOU WIDE	.13									+
TOTAL	15,318	11,446	16,069	11,449	3,078	11,405	16,083	84,848		
			,				,	84,848		
		'						'		
	ON									
ALLOCATI		DIADD	III TD	N/II.E	MEADII	MENARO	OLINDICE	TOTAL		1
PERCENT. 2001	AGE	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL		+
JANUARY		18.81%	14.02%	17.64%	18.37%	14.04%	17.12%	100.00%	-	1
EBRUAR	Y	18.96%	14.02%	18.66%	17.39%	13.89%	16.93%	100.00%		1
MARCH		18.26%	13.28%	18.84%	17.34%	13.31%	18.97%	100.00%		1
APRIL		18.18%	13.05%	19.11%	16.72%	12.93%	20.01%	100.00%		
MAY		17.71%	13.84%	19.27%	16.65%	12.57%	19.96%	100.00%		
JUNE		17.54%	13.23%	19.40%	16.34%	13.70%	19.80%	100.00%		
			12.91%	19.61%	17.07%	13.71%	19.67%	100.00%		